

CERTIFICATE OF DEATH

Reg. Dist. No. 245

8572

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, 6 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescing Home, Hyattsville, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Maude Agnes Anderson				4. DATE OF DEATH Month Day Year August 13, 19 56			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 Jan. 1879	
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward Daniels				14. MOTHER'S MAIDEN NAME Clara Ricar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Claude Anderson, Husband Same as no. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic glomerulo-nephritis with uremia. 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 2 wks. 20 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 56, to August 19 56, that I last saw the deceased alive on August 13, 19 56, and that death occurred at 7: P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. 4713 Berwyn Rd. College Park, Md. PHYSICIAN'S NAME (Type) Wolcott L. Etienne, M.D. 4713 Berwyn Road Collage Park, Maryland 8/14/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 August 56		22c. NAME OF CEMETERY OR CREMATORY St. John's Church Cemetery Beltsville Pr. Geo., Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE Aug. 17 1956 ms. Jas. Severe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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1956

BUREAU V. 1

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8583

CERTIFICATE OF DEATH

08550

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George Gen. Hosp.</u>		d. STREET ADDRESS <u>604. 10th STREET</u>	
3. NAME OF DECEASED (Type or print) <u>Daisy</u> First <u>Blue</u> Middle Last		4. DATE OF DEATH <u>Aug. 17, 1956</u> Month Day Year	
5. SEX <u>7</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 30, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>SEVERN MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HIRAM GAITHER</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE BYRD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS DORIS SPALDING, LAUREL, MD</u>	
17. INFORMANT <u>MRS DORIS SPALDING, LAUREL, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Embolus</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypernephroma Right Kidney</u> DUE TO (c) <u>3 mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE Cardio Vascular Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>a. m.</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 9, 1956</u> to <u>Aug 17, 1956</u> that I last saw the deceased alive on <u>Aug 16, 1956</u> and that death occurred at <u>10 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comen</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Bkny St</u> DATE SIGNED <u>8/17/56</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEN</u>		<u>MT Rainier Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 20, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Muirkirk, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hossaldory Laurel Md</u>		24a. REC'D BY REGISTRAR <u>AUG 22 1956</u> 24b. REGISTRAR'S SIGNATURE <u>A. H. Hossaldory</u>	

CERTIFICATE OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allentown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allentown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6901 Allentown Road		e. STREET ADDRESS 6402 Temple Hill Road	
3. NAME OF DECEASED (Type or print) First Harlan Middle Edward Last Bowman		4. DATE OF DEATH Month August Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1908
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 47 Days 47 Hours 47 Min. 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel N. Bowman		14. MOTHER'S MAIDEN NAME Cora L. Shepherd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Mary Bowman, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED August 2, 1956	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition BURIAL		22b. DATE THEREOF 8-6-1956	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) SUITLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24. REGISTRY SIGNATURE A.W. Hedrich	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 7 1956

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8573

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN TB 3 Mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paint Branch Rest Home		d. STREET ADDRESS 4316 Hartwick Road	
3. NAME OF DECEASED (Type or print) Annie First Ireland Middle Boyle Last		4. DATE OF DEATH Aug Month 14 Day 1956 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Sept, 1868
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Kent Boyle		14. MOTHER'S MAIDEN NAME Elizabeth Veitch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Fletcher P. Veitch Jr.		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PAGETS DISEASE			
INTERVAL BETWEEN ONSET AND DEATH 30 min 5 years 15 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 53 , to August , 19 56 , that I last saw the deceased alive on Aug 2 , 19 56 , and that death occurred at 5:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William Dond (bmeau)		ADDRESS (Street, city or town, state) 3503 Lennox St	
PHYSICIAN'S NAME (Type) DR. DONAT (bmeau)		DATE SIGNED 8/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR Aug 17 1956	
ADDRESS Hyattsville, Maryland		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

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Item 4, FilmG202 8-27-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

247

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7219 Central av.</u>				d. STREET ADDRESS <u>7219 Central ave</u>			
3. NAME OF DECEASED (Type or print) <u>BERNARD FRANCIS BRADY</u>				4. DATE OF DEATH <u>August 17, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 7, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BINK. BRADY</u>				14. MOTHER'S MAIDEN NAME <u>MARY ANN HAVEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Oscar W. Brady Sandover, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial heart disease with chronic congestive failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>June 2, 1951</u> , to <u>Aug 17, 1956</u> , that I last saw the deceased alive on <u>Aug 16, 1956</u> , and that death occurred at <u>9:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest E. Cornelson</u> M.D. <u>4400 Bower Pl. SE</u>				DATE SIGNED <u>8/17/56</u>			
PHYSICIAN'S NAME (Type) <u>ERNEST E. CORNELSON</u>				<u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>		22d. LOCATION (City, town, or county) <u>Seat Pleasant, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington D.C.</u>				24a. REC'D BY REGISTRAR <u>Aug 20 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

MAY 20 1956

RECEIVED

8584

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundelle</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linnet</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Junction</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>402 Main St</u>			d. STREET ADDRESS <u>Brink Bridge Rd</u>		
3. NAME OF DECEASED (Type or print) <u>Michael David Bright</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1956</u>		9. AGE (In years last birthday) yrs <u>3</u> Months <u>3</u> Days <u>3</u> Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			13. FATHER'S NAME <u>Jack Bright</u>		
14. MOTHER'S MAIDEN NAME <u>Betty Marie Souder</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Father & Mother (above)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Enteritis, Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Aug 19</u> , 19 <u>56</u> , to <u>Aug 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>56</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Robert S. McConey</u> M.D.			ADDRESS (Street, city or town, state) <u>402 Main St</u>		
PHYSICIAN'S NAME (Type) <u>Robert S. McConey, M. D.</u>			DATE SIGNED <u>8/20/56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Scaggsville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Lavalley</u>			24a. REC'D BY REGISTRAR <u>Aug 23 - 56</u>		
ADDRESS <u>Laurel, Md</u>			24b. REGISTRAR'S SIGNATURE <u>M. Brashers</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 24 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

8535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08555

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 3 Mo. 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 6202 Brooks Road, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ABRAHAM Middle BENJAMIN Last BROWN, Sr.				4. DATE OF DEATH Month August Day 28th, Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9th, 1882	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Louisanna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Benjamin Brown				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Pennington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lota Belle Brown, 7628 Greeley Road, Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO 104.0 Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Fractured Right Shoulder PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell and fractured right shoulder					
20c. TIME OF INJURY Month, Day, Year Hour XXX 5/5/56 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Capitol Hgts. Pr. Geo. Co. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 31/1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517--11th St. S.E. Wash. D.C.				24a. REC'D BY REGISTRAR DATE AUG 31 1956		24b. REGISTRAR'S SIGNATURE James Lewis	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used for burial-transit permit. File pages 1 and 2 with the registrar prior to burial. Information, or removal.

BUREAU V. S.

9501 1 E.A.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8586 CERTIFICATE OF DEATH

Reg. Dist. No.

08556
231

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AQUASCO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCE GEORGES GEN. HOSP		d. STREET ADDRESS AQUASCO	
3. NAME OF DECEASED (Type or print) First LEO Middle BROWN Last BROWN		4. DATE OF DEATH Month Aug. Day 19 Year 1956	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD
13. FATHER'S NAME LEO BROWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LEO BROWN		Address AQUASCO, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Purulent Meningitis (H. Influe) 3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/14, 1956 , to 8/19, 1956 , that I last saw the deceased alive on 8/19, 1956 , and that death occurred at 1:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE T. H. Bergemann		DATE SIGNED 2728 7442 PM Hyattsville	
NAME (Type) T. H. Bergemann			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8-21-56	22c. NAME OF CEMETERY OR CREMATORY John Wesley	22d. LOCATION (City, town, or county) (State) AQUASCO, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Harold Funeral Home		24b. REGISTRAR'S SIGNATURE H. H. Hedrick	
ADDRESS 2nd		DATE AUG 28 1956	

BUREAU N. S.

AUG 23 1954

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 18558
 8574
 CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE				c. LENGTH OF STAY IN 1b 4 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4019 Kennedy ST				d. STREET ADDRESS 2151 Florida Ave. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Frederick Buttor				4. DATE OF DEATH August 19 1956			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 6, 1887	
				9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INTERIOR DECORATOR				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK MILLS N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Frederick Buttor				14. MOTHER'S MAIDEN NAME Bertha Ormsby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Margorie Barkisch Address 4019 Kennedy ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 142.1 CARCINOMATOSIS DUE TO (b) CARCINOMA OF PAROTID GLAND (c) 3 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 28, 1956, to Aug 19, 1956, that I last saw the deceased alive on Aug 4, 1956, and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Noel Ormeau M.D.				ADDRESS (Street, city or town, state) 3503 RANNEY ST		DATE SIGNED 8/19/56	
PHYSICIAN'S NAME (Type) NORMAN NOEL ORMEAU				MT RAINIER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-19-56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) WASH. DC	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest Adams ADDRESS 4728 Wisconsin FIVE MD				24a. REC'D BY REGISTRAR DATE Aug 19, 1956 Mrs. Jas. Severe		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

AUG 21 1956

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film G201 8-20-50
8587
CERTIFICATE OF DEATH

08559

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PR Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PR Geo.</u> <u>16X-2</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>23</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Home</u>		d. STREET ADDRESS <u>5504 Parkland Court</u> <u>2401 Cheverly Ave. Cheverly</u>	
3. NAME OF DECEASED (Type or print) <u>Rachel</u> First <u>W.</u> Middle <u>CARRICK</u> Last		4. DATE OF DEATH <u>AUG 10</u> Month <u>19</u> Year <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 9, 1876</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>N.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>N.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>6819-Geo Palmer Ky</u>	
17. INFORMANT <u>Mr. Richard Langan</u> Address <u>6819 Geo Palmer Ky</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u> DUE TO (c) <u>54RS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (GIVEN IN PART I) <u>TUMOR RT FEMUR WITH PATHOLOGICAL FRACTURE CHOS</u> <u>MULTIPLE DECUBITUS ULCERS - CONTRACTURE LEFT ARM</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter date of injury in Part II of Form No. 1) <u>FRAC RT HUMERUS (54RS)</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL</u> , 19 <u>55</u> to <u>10 AUG</u> , 19 <u>56</u> that I last saw the deceased alive on <u>9 AUG</u> , 19 <u>56</u> , and that death occurred at <u>11:40 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3404 CHEVERLY AVE</u> DATE SIGNED <u>John Kehoe</u> M.D. <u>CHEVERLY, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 13, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Adrian Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lewis</u> ADDRESS <u>3004 1st St</u>		24a. REC'D BY REGISTRAR <u>A. W. Hedrick</u> DATE <u>10-10-56</u>	
24b. REGISTRAR'S SIGNATURE			

22

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JAN 9 1875

A. S. J. ...

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BUREAU V. E.

AUG 16 1956

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18560

CERTIFICATE OF DEATH

Reg. Dist. No.

231

8588

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>4723-Homer Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Hilda</u> Middle <u>Clark</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-25</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>7</u> Min <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Haynes</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Edward Clark 4723 Homer Ave Suitland MD</u>	
17. INFORMATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral haemorrhage</u> DUE TO <u>Ruptured congenital aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7/10</u> DUE TO (c) <u>23 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>1956</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/18</u> , 19 <u>56</u> , to <u>8/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/2</u> , 19 <u>56</u> , and that death occurred at <u>2:22 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Thomas Lord</u> M.D.		ADDRESS (Street, city or town, state) <u>2025 Eye St. N.W. Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>John Thomas Lord</u>		DATE SIGNED <u>8/2/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-4-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Hall</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mettingly Funeral Home - 131-11 St. S.E.</u>		24a. REC'D BY REGISTRAR <u>G 3</u> 19 <u>56</u>	
ADDRESS <u>WASH. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

DEWEY V. E.

AUG 1 1950

RECEIVED

8539
CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Radiant Valley	
		d. STREET ADDRESS 6807 Sherperd Street	
3. NAME OF DECEASED (Type or print) First Middle Last Thompson Huff Clark		4. DATE OF DEATH Month Day Year August 16 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Aug. 1880
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter Self		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joshua Clark		14. MOTHER'S MAIDEN NAME Sarah Huff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 146 10 7023	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung, Metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Atherosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 5 months 1 year 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 5, 1956, to Aug 16, 1956, that I last saw the deceased alive on August 15, 1956, and that death occurred at 12.00 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Gorden W. Kelley		ADDRESS (Street, city or town, state) 6124-41st Ave, Hyattsville, Md	
PHYSICIAN'S NAME (Type) Gorden W. Kelley		DATE SIGNED 8/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/20/56	22c. NAME OF CEMETERY OR CREMATORY Mantua Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Mantua New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland	
24a. REG'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE W. H. Redwood	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 20 1956

RECEIVED

8632

CERTIFICATE OF DEATH

18562

Reg. Dist. No.

247

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switzland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switzland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4819 Silver Hill Road</u>				d. STREET ADDRESS <u>4819 Silver Hill Road</u>			
3. NAME OF DECEASED (Type or print) <u>Judson Jean Creeay</u>				4. DATE OF DEATH <u>Aug 20 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9-1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward A Creeay</u>				14. MOTHER'S MAIDEN NAME <u>Emzelia E. Pea</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>313-124038</u>		17. INFORMANT <u>Edward A Creeay</u> Address <u>4819 Silver Hill Road Switzland Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Congestive Failure</u> <u>162X</u> DUE TO (b) <u>Myocardia (Insufficiency)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Bronchogenic Carcinoma - L.U.L.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 months</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1954</u> to <u>August 20, 1956</u> that I last saw the deceased alive on <u>August 19, 1956</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above. P. ADDRESS (Street, city or town, state) <u>7200-11th L. BORO PIKE SE 28 DC</u> DATE SIGNED <u>8/20/56</u>							
ACTUAL SIGNATURE <u>Sidney H. Lowry</u> M.D. <u>7200-11th L. BORO PIKE SE 28 DC</u>				PHYSICIAN'S NAME (Type) <u>S. H. LOWRY M.D. DISTRICT HEIGHTS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-</u>		22b. DATE THEREOF <u>1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany</u>		22d. LOCATION (City, town, or county) (State) <u>Landestriele Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A Mattingly</u> ADDRESS <u>131-11th St Washington DC</u>				24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Barrie Campbell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in no event within 72 hours after death.

RECEIVED
AUG 22 1956
BUREAU V S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08563

CERTIFICATE OF DEATH

8633

Reg. Dist. No. 231

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Prince George's</u> MARYLAND	STATE <u>MD.</u> COUNTY <u>PR. Geo.</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hillside</u>	LENGTH OF STAY (in this place) <u>47 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hillside</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1106 - 56th Ave.</u>	STREET ADDRESS (If rural give location) <u>1106 - 56th Ave.</u>		
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Flvine F. CROSSMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>aug 6 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>JAN. 22 - 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>73</u> yrs
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD HAITFAP</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS <u>Ludwig CROSSMAN</u> <u>1106 - 56th Ave.</u>	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)		Arteriosclerotic Heart Disease		10 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>1947</u> to <u>8-6-1956</u> , that I last saw the deceased alive on <u>8-6-1956</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above				
SIGNATURE <u>Reuben E. Stone</u>		ADDRESS (Street, city, town, state) <u>M.D. 3417 Minnesota Washington DE 8/6/56</u>		DATE SIGNED <u>DE 8/6/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial Aug 9-56</u>	DATE THEREOF <u>Aug 9-56</u>	NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>		LOCATION (City, town, or county) (State) <u>Seat Pleasant</u>
24. REC'D BY REGISTRAR <u>H. H. Reduch</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bro.</u>		ADDRESS <u>1661-1600 N. W. Rd SE W.F.S.H. DC</u>

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

1956 AUG 8

1956 AUG 8

1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give flag 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8590 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08564

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) IRVINGTON					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.				d. STREET ADDRESS Box 63		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Victory Last Dawson				4. DATE OF DEATH Month August Day 4 Year 1956					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1906			
9. AGE (In years last birthday) 49 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Austin G. Clarke				14. MOTHER'S MAIDEN NAME Martha K Davis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT William C. Christopher Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial pressure 330x DUE TO Conditions, if any, which gave rise to immediate cause (b) Spontaneous subarachnoid hemorrhage (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 4, 1956					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/56		22c. NAME OF CEMETERY OR CREMATORY Bulah Cemetery		22d. LOCATION (City, town, or county) (State) Lively Va.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REG'D BY REGISTRAR AUG 7 1956			
				24b. REGISTRAR'S SIGNATURE R. W. Schuch					

ROBERT W. S.

1906

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

Reg. Dist. No. 12

118565

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DuPont Hts. md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges</u>		d. STREET ADDRESS <u>4416 Campbell DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>DENT</u> Last <u>DENT</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-72</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pri. Geo. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Galloway</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>740.0</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Ah Disease</u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>8-19, 1956</u> to <u>8-19, 1956</u> , that I last saw the deceased alive on <u>8-19, 1956</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ronald S. Fleischer</u> M.D.		ADDRESS (Street, city or town, state) <u>1732 Beechwood Rd. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>		DATE SIGNED <u>8/20/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Aug-23, 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOOD LAWN</u>	22d. LOCATION (City, town, or county) <u>DC</u> (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. K. Rollins</u>		ADDRESS <u>4339 Hunt Pl</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Corree Campbell</u>	

1956

8592

CERTIFICATE OF DEATH

Reg. Dist. No.

18566
239

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b 36 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 158 Lafayette Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 158 Lafayette Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry J. Dudley		4. DATE OF DEATH Month Aug Day 12 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1867
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Stephen Dudley		14. MOTHER'S MAIDEN NAME Elizabeth A. Holbrooke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John A. Jones		Address 158 Lafayette Ave, Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema - Hypertension DUE TO Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO Arteriosclerosis - Myocardial Infarction (c) Arteriosclerosis - Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/2 , 19 56 , to 8-12 , 19 56 , that I last saw the deceased alive on 8-12 , 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Steward		M.D. 314 Conf - an	
PHYSICIAN'S NAME (Type) W.B. Steward		DATE SIGNED 8/12/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 15, 1956	
22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.B. Steward		24a. REC'D BY REGISTRAR Aug 15-56	
ADDRESS Laurel, Md.		24b. REGISTRAR'S SIGNATURE M. Brashear	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 20 1956

RECEIVED

8 X 11 INCHES

ONE

10-11-11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, or mailing, or removal.

- MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18 88568

28594 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverville				c. LENGTH OF STAY IN TB 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 4306 Tuckerman Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Alexander Last Fearing				4. DATE OF DEATH Month August Day 8 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/59		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Cent.		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Fearing				14. MOTHER'S MAIDEN NAME Cordelia Baird			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Name Mrs. Malcolm Kerr Address Same as # 2 Daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) Fractured left femur						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell down in his front yard on side walk			
20c. TIME OF INJURY Month, Day, Year Hour 8:00 P.M. 6-12-56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) University Park-Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 9th, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 8/9/56		22c. NAME OF CEMETERY OR CREMATORY Robbins Funeral Home		22d. LOCATION (City, town, or county) (State) Williams, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR 13 1956	
				24b. REGISTRAR'S SIGNATURE John T. Maloney			

JOHN A. HENRY

1899

8634

CERTIFICATE OF DEATH

Reg. Dist. No.

230

1. PLACE OF DEATH a. COUNTY <u>PR Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mellville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4411 - GUCCA</u>		d. STREET ADDRESS <u>40 FRANKLIN ST</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>MARGARET</u> Middle <u>FELTMEYER</u> Last		4. DATE OF DEATH <u>AUG</u> Month <u>1</u> Day <u>1956</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Zealosh Yingling</u>		14. MOTHER'S MAIDEN NAME <u>Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-24-5868</u> INFORMANT <u>PROPS</u> Address <u>4411 GUCCA, Mellville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL Myeloma (Metastatic)</u> DUE TO (b) <u>Myeloma - Thoracic Spine</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>AUG</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JULY 31</u> , 19 <u>56</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.		DATE SIGNED <u>4713 - BERWYN RD</u>	
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>		<u>COLLEGE PARK, MD</u>	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>—</u>	22b. DATE THEREOF <u>8-3-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Sons Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u> DATE <u>8/2/56</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF JUSTICE

AUG 1 1960

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8635

CERTIFICATE OF DEATH

Reg. Dist. No.

085704

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
		d. STREET ADDRESS <u>Route 2, Box 416</u>	
3. NAME OF DECEASED (Type or print) <u>Frank William Ferrel</u>		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-1892</u>
9. AGE (In years, last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bloomsburg, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lymon Ferrel</u>		14. MOTHER'S MARRIED NAME <u>Eva Loup</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-19-388</u>	
17. INFORMANT <u>Son: Lymon J. Ferrel</u>		Address <u>8 Martha St. Parkville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO (b) <u>arteriosclerosis of coronary artery</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (State nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>4:45 P</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>9-15-52</u> to <u>8-5-56</u> , that I last saw the deceased alive on <u>7-30-56</u> , and that death occurred at <u>4:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard Gitter</u> M.D.		ADDRESS (Street, city or town, state) <u>656 East Cap St, Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD GITTER, M.D.</u>		DATE SIGNED <u>Aug 10 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Washington, D.C.</u>		24. REC'D BY REGISTRAR <u>Carrie Campbell</u>	
25. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE	

P. LEAU V. L.

1956

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08571

Reg. Dist. No. 282

8636

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morning side		c. LENGTH OF STAY IN 1b 5 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morning side			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6211 Mc Keldin Drive				d. STREET ADDRESS 6211 Mc Keldin Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Lena Frederick				4. DATE OF DEATH Aug 19 1956			
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 30 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Sun Hall		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry Thomas				14. MOTHER'S MAIDEN NAME Susan Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Frederick Address 4444 1st St. N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Cancer of the rectum DUE TO (b) _____ DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Aug 19, 1956	
EXAMINER'S NAME (Type or print) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/22/56		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		22d. LOCATION (City, town, or county) BUSHWOOD, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.B. Robinson				ADDRESS LEONARDTOWN, Md.		24a. REC'D BY REGISTRAR 8/20/56	
				24b. REGISTRAR'S SIGNATURE Glenn D. Houser			

MEDICAL CERTIFICATION

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial/cremation or removal.

RECEIVED

AUG 21 1936

BUREAU V. S.

8595
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY P. G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. Brentwood	
c. LENGTH OF STAY in lb 4 1/2 hours		d. STREET ADDRESS 4500 41st Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Granville Gaither		4. DATE OF DEATH Month Day Year August 20 19 56	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-84
9. AGE (In years last birthday) 71 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator U.S. Govt.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Gaither		14. MOTHER'S MAIDEN NAME Martha E. Wattemo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Marion Hawkins 4502 41st Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A. I Bleeding DUE TO Small intestinal obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cause unknown DUE TO Mesenteric Thrombosis (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20, 1956, to 8/21, 1956, that I last saw the deceased alive on 8/20, 1956, and that death occurred at 5:10AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Holbrook M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 8/21/56	
PHYSICIAN'S NAME (Type) William A. Holbrook			
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-24-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY CARVER Memorial		22d. LOCATION (City, town, or county) (State) Prince Geo. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Washington & Son 467 N. St. N.W.		24a. REC'D BY REGISTRAR DATE 231	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88573

Reg. Dist. No.

137

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westwood</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnuder Ferry Road</u>				d. STREET ADDRESS <u>Magnuder Ferry Road</u>			
3. NAME OF DECEASED (Type or print) <u>Evelyn Catherine Goldsmith</u>				4. DATE OF DEATH <u>Aug 18 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>38</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth O'Hanlon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Howard L. Goldsmith same as II...</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> <u>140</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>short circuit in vacuum cleaner</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injured in vacuum cleaner that short circuited</u>							
20c. TIME OF INJURY <u>11:00 a.m. 8/18/56</u>		20d. INJURY OCCURRED <u>While at work</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Westwood P.S.</u> (County) <u></u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>		22d. LOCATION (City, town, or county) <u>Horsehead</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Brothers</u> ADDRESS <u>Upper Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 23 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John F. Dwyer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To burial, cremation, or removal.

R. A. C. 1956

AUG 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8595 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88574
231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4310 Baltimore Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hubert Earl Greene		4. DATE OF DEATH Month Day Year August 29 1956		5. SEX Male			
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10, 1928			
9. AGE (In years last birthday) 28 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction engineer		11. BIRTHPLACE (State or foreign country) Florida			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Marcus Greene		14. MOTHER'S MAIDEN NAME Mary Lou Futch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W.W. II		16. SOCIAL SECURITY NO.		17. INFORMANT Address Charles Tessier, 5506 40th Ave, Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Crushed chest DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Road grading machine went thru guard rail of bridge and overturned in ravine below pinning deceased underneath.					
20c. TIME OF INJURY Month, Day, Year 3:15 p. m. 8-29-56		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street			
20f. (City or town) Lenham, Pr. Geo. Maryland		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 30, 1956			
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Interment		22b. DATE THEREOF 8/31/56		22c. NAME OF CEMETERY OR CREMATORY Jacksonville			
22d. LOCATION (City, town, or county) Florida		22e. (State)		24a. REC'D BY REGISTRAR SEP 7 1956			
23. FUNERAL DIRECTOR'S SIGNATURE F. J. ...		ADDRESS ...		24b. REGISTRAR'S SIGNATURE ...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 2 1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8579

CERTIFICATE OF DEATH

Reg. Dist. No.

08575
245

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Rainier</u>	
c. LENGTH OF STAY IN 1b <u>20 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4511 32nd Ave</u>		d. STREET ADDRESS <u>4511 32nd Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Adele</u> Last <u>GRIFFITH</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Gent</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Griffith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Kathryn Flanagan</u> Address <u>4511 32nd Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 years</u> (c) <u>5 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 1951, to <u>Aug 12</u> , 1956, that I last saw the deceased alive on <u>Aug 11</u> , 1956, and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat O'neal</u> M.D. <u>3503 Penny St Mt Rainier</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8/12/56</u>	
PHYSICIAN'S NAME (Type) <u>Norman Donat O'neal</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-15-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Lintner</u> ADDRESS <u>5932 N. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 14 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u> <u>Revere</u>	

BUREAU V. B.

AUG 16 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8597 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08576

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Fletchertown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle Webster Last Hall				4. DATE OF DEATH Month August Day 29 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1900		9. AGE (In years last birthday) 56 yrs.	1F UNDER 1 YEAR Months 56 Days 56	IF UNDER 24 HRS Hours 56 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Road Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick W. Hall				14. MOTHER'S MAIDEN NAME Emma Jane Lounde			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-12-9689		17. INFORMANT Maria Hall, Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 441X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED August 29, 1956			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/1/56		22c. NAME OF CEMETERY OR CREMATORY Church of Ascension		22d. LOCATION (City, town, or county) (State) Bowie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stewart				ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR SEP 5 1956	
				24b. REGISTRAR'S SIGNATURE A. H. Schick			

23

BUREAU V. S.

SEP 5 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

185577

Reg. Dist. No.

243

8638

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall's Hill c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Court at Home				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hall's Hill d. STREET ADDRESS 1961 Calverton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Van Meter Harrison				4. DATE OF DEATH Month Day Year Aug 4 1956			
5. SEX male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 15 1933	
9. AGE (In years last birthday) 22 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Washer		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Van Meter, Sr.				14. MOTHER'S MAIDEN NAME Catherine I Barber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph V. Harrison Jr. Address 1961 Calverton Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Crushed skull and abdomen DUE TO (c) Compound comminuted fracture - both legs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by an automobile			
20c. TIME OF INJURY Hour o. m. 3:00 p. m. Month, Day, Year 8-4 1956				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Calverton				20f. (City or town) (County) (State) Hall's Hill Prince Georges Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED Aug 4, 1956			
EXAMINER'S NAME (Type) JAMES I. BOYD				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE FRAZIER'S				24a. RECD BY REGISTRAR ADDRESS 387 R I Ave			
24b. REGISTRAR'S SIGNATURE				24c. DATE AUG 15 1956			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

UG 8 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18578

8575

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leonard Middle Martin Last Hendricks				4. DATE DEATH Month Aug Day 27 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1910	
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 46 Days 0 Hours 0 Min. 0		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Express				10b. KIND OF BUSINESS OR INDUSTRY Truck Driver		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Arthur P. Hendricks				14. MOTHER'S MAIDEN NAME Ethel Shobe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W W 11		17. INFORMANT Address Elizabeth W. Hendricks Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of head (c) DUE TO (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Self inflicted wound while sitting alone in his automobile.							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted wound while sitting alone in his automobile.					
20c. TIME OF INJURY Hour 12.45 m. 8-27-56 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off co bldg., etc.) Rear of home		20f. (City or town) (County) (State) West H^{att}sville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/56		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR AUG 30 1956	
				24b. REGISTRAR'S SIGNATURE James Jones			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED
AUG 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8639

CERTIFICATE OF DEATH

Reg. Dist. No. 18579
273

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>1 yr., 3 mos.</u>				d. STREET ADDRESS <u>1115 Montague St., N. W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>O.</u> Last <u>Hudson</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/28/1906</u>	
9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>		IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George P. Hudson</u>				14. MOTHER'S MAIDEN NAME <u>Annie M. Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-07-9875</u>		17. INFORMANT <u>Decedent</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced pulmonary tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr., 5 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>-</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	
20f. (City or town) <u>-</u>				20g. (County) <u>-</u>		20h. (State) <u>-</u>	
21. I certify that I attended the deceased from <u>1/27/1955</u> , to <u>8/16/1956</u> , that I last saw the deceased alive on <u>8/16/1956</u> , and that death occurred at <u>6:50 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>8/16/56</u>							
ACTUAL SIGNATURE <u>Daniel Leo Finucane</u> M.D.				PHYSICIAN'S NAME (Type) <u>Daniel Leo Finucane, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify). <u>Removal</u>				22b. DATE THEREOF <u>8/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. W. Henderson</u>				ADDRESS <u>2. Beene Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>8/16/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. W. Weir</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 22 1956

BUREAU V. S.

8598

CERTIFICATE OF DEATH

Reg. Dist. No. 231

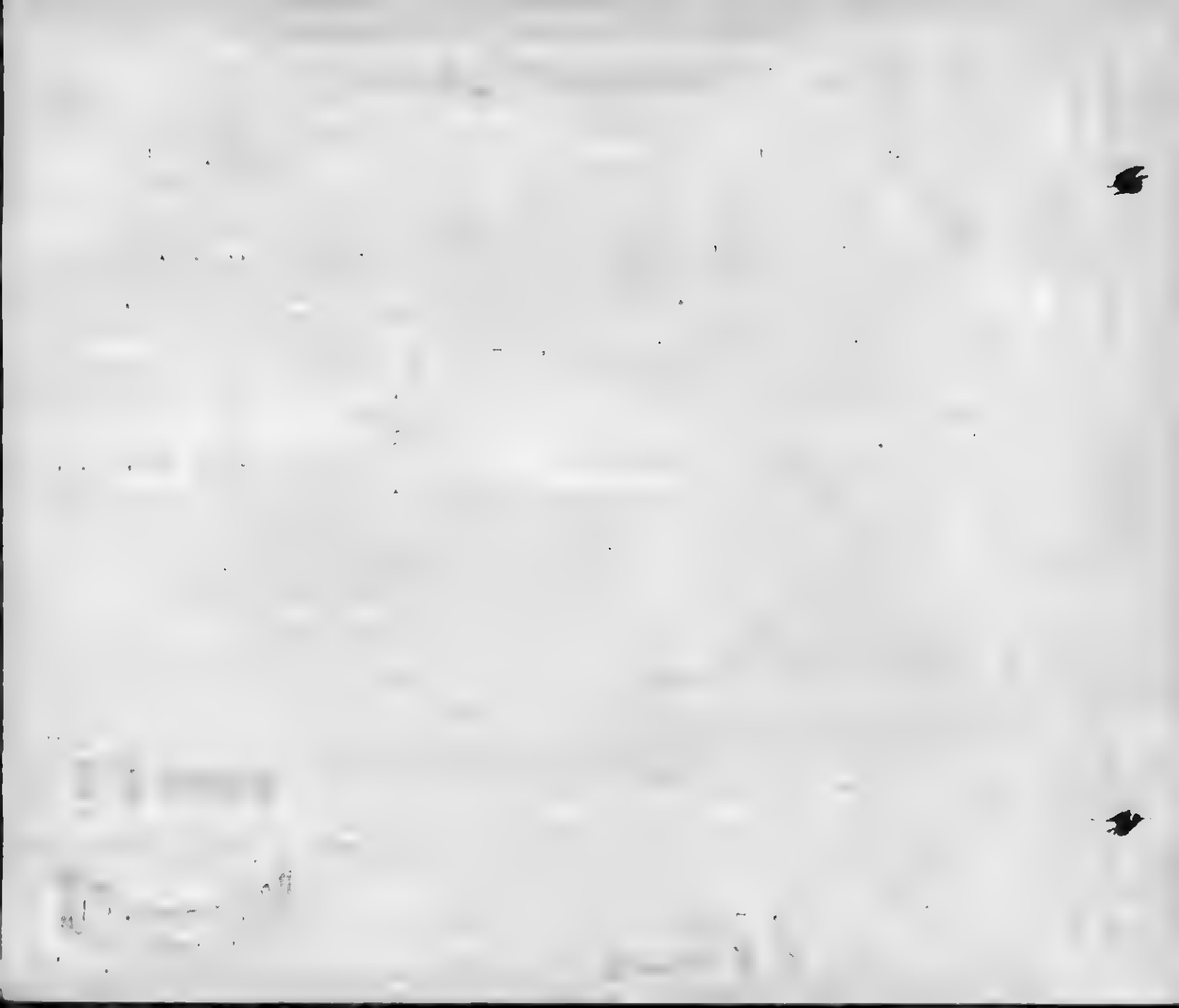
1. PLACE OF DEATH COUNTY Prince George's MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince George's General				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Pr. Geo's CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bradbury Park STREET ADDRESS (If rural give location) 5613- Belt Ave., S. E.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) OSCAR R. HUTTON				4. DATE OF DEATH (Month) (Day) (Year) August 3rd. 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 22-1878	9. AGE last birthday 78 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Contrator		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William P. Hutton				14. MOTHER'S MAIDEN NAME Sarah Wolfe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS 5613- Belt Ave., S.E. Flora I. Hutton			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 451.0 IMMEDIATE CAUSE (A) Congestive Heart Failure ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Mania, Chronic				INTERVAL BETWEEN ONSET AND DEATH Unknown " "			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/14/56, 1956, to 8/3/56, 1956, that I last saw the deceased alive on 8/3/56, 1956, and that death occurred at 1:10 PM, from the causes and on the date stated above. SIGNATURE John I. Hutton M.D. 5241 St. Barnabas Rd. SE Md. 8/3/56 ADDRESS (Street, city, town, state) DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug. 6- 1956		NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		LOCATION (City, town, or county) (State) Suitland, Maryland.	
24. REC'D BY REGISTRAR AUG 5 1956		REGISTRAR'S SIGNATURE A. W. Hedrick		25. FUNERAL DIRECTOR'S SIGNATURE Simmons		ADDRESS 1661- Good Hope Rd. SE Washington D.C.	

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

185581

Reg. Dist. No.

442

8640

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Leonard</u> c. LENGTH OF STAY IN 1b <u>12 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10908-13 Street</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Leonard</u> d. STREET ADDRESS <u>6908-13 Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles J. Fayette Jacob</u> First Middle Last				4. DATE OF DEATH <u>Aug 31 1952</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 1, 1908</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>44 yrs.</u> UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John H. Jacob</u>				14. MOTHER'S MAIDEN NAME <u>Annie Louise</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-57-6007</u>				17. INFORMANT <u>Virginia D. Jacob, Carroll</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute gastritis, acute hemorrhagic pancreatitis</u> DUE TO (c) <u>Alcoholism</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James I. Boyd</u> EXAMINER'S NAME (Type) <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Aug 31, 1952</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co. MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u> ADDRESS <u>317 Pa. Ave. S.E. Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>Arrie Campbell</u> DATE <u>9/3/52</u>		24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to a Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE A. J. J. J. J.

THE A. J. J. J. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8599

CERTIFICATE OF DEATH

8582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hall</u>	
c. LENGTH OF STAY IN IS <u>4 Hours</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>James</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Aug 56</u>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Byrd</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hattie Meloris James</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>mother - as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abnormal pulmonary ventilation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (premature 1 lb. 10 oz)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/4</u> , 19 <u>56</u> , to <u>8/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>56</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D.		ADDRESS (Street, city or town, state) <u>College Park, Md</u>	
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>		DATE SIGNED <u>8/7/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation Aug 1956</u>		22b. DATE THEREOF	
23. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Indian Burial</u>		22c. LOCATION (City, town, or county) (State) <u>Cheverly Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Penn Jr</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>ADW. H. H. H.</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>8/18/56</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 5810 Cleveland Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gayle Middle PORTHULA Last Johann				4. DATE OF DEATH Month August Day 3 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16 1916	
9. AGE (In years last birthday) 39 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Business Adm.		11. BIRTHPLACE (State or foreign country) Oklahoma	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Earl P. Dean			
14. MOTHER'S MAIDEN NAME Almeria Moore				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 448-07-0029				17. INFORMANT Francis J. Johann Cape May N. J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Fulminating DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 0. 01 Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hyattsville				20g. (County) Prince George			
20h. (State) Md.							
21. I certify that I attended the deceased from June 1956 , to Aug. 3, 1956 , that I last saw the deceased alive on August 3, 1956 , and that death occurred at 3:15 A.M. on the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 6124-41st. Ave. Hyattsville Md.				DATE SIGNED 8/3/56			
ACTUAL SIGNATURE Gordon W. Kelly				M.D. 6124-41st. Ave. Hyattsville Md.			
PHYSICIAN'S NAME (Type) Gordon W. Kelly				6124-41st. Ave. Hyattsville, Md.			
22a. BURIAL-CREMATATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-10-56		22c. NAME OF CEMETERY OR CREMATORY Holdenville Cem.		22d. LOCATION (City, town, or county) (State) Holdenville Oklahoma	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Chamber C.				ADDRESS 5801- Cleveland Ave		24a. REC'D. BY REGISTRAR 1956	
				24b. REGISTRAR'S SIGNATURE A. H. F. F. F.			

BUREAU V. B.

10 2 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

118584

CERTIFICATE OF DEATH

Reg. Dist. No. 284

8641

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hgts.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hgts Maryland</u>			
c. LENGTH OF STAY IN 1b <u>5 years</u>				d. STREET ADDRESS <u>338-Huron Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>338-Huron Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA A JOSEPHINE JOHNS</u>				4. DATE OF DEATH Month Day Year <u>8 - 23 19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2, 1884</u>	
9. AGE (In years last birthday) yrs <u>71</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Larson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>A. F. Young</u> Address <u>122-Box Way Forest Hgts</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Starvation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the Pancreas.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-23-</u> , 19 <u>56</u> , to <u>8-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-22</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Etienne Szollosi</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2. Park Way Drive 8-23-56</u>			
PHYSICIAN'S NAME (Type) <u>Etienne Szollosi</u>				FOREST Hgts. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-25-1956</u>		<u>Forest Lincoln</u>		<u>Bladensburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Thompson</u>				ADDRESS <u>512-11th St S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>8/27/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carric Campbell</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 Filed 9-3-56 et

CERTIFICATE OF DEATH

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731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chervely				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Annie Kaplan				4. DATE OF DEATH Month Day Year August 30 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11 1889	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Zalman Levin				
14. MOTHER'S MAIDEN NAME Rachel --Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. NONE			17. INFORMANT Simon Kaplan 730 Congress St SE				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia - DUE TO (c) Anasarca PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)		20h. (State)		
21. I certify that I attended the deceased from Aug 16, 1956, to Aug 29, 1956, that I last saw the deceased alive on Aug 29, 1956, and that death occurred at 1, 15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE George B. Nsenge M.D.							
PHYSICIAN'S NAME (Type) George B. Nsenge							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8/31-1956		TIFERETH-ISRAEL Cem.		Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 4217-9th St NW Goldberg Funeral Home Wash. DC							
24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE				
31 1956			M. St. Reduch				

BUREAU V. E.

AUG 21 1956

RECEIVED

8602

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst. before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen. Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs	
		d. STREET ADDRESS 8207 Sebrider Street	
3. NAME OF DECEASED (Type or print) First Bernard Middle J. Last Kinnahan		4. DATE OF DEATH Month Aug. Day 2, Year 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, '06
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Post Office	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter P. Kinnahan		14. MOTHER'S MAIDEN NAME Gennieve Pence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT John Kinnahan, Bethesda, Md. Brother		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest (c) Automobile accident DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Passenger in an automobile in collision with another.	
20c. TIME OF INJURY Month, Day, Year Hour 7:15 P. M. 8-2- 19 56		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Laurel, Pr. Geo. Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF 8/11/56	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) WASHINGTON, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Humphrey		24a. REC'D BY REGISTRAR AUG 14 1956	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE A. H. Hedrich	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK

AUG 14 1956

RECEIVED

CERTIFICATE OF DEATH

18587
Reg. Dist. No. 231

8603

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>1800 Nichols Ave., S.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>Kramer</u>		4. DATE OF DEATH <u>Aug. 17, 1956</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>M</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1956</u> 9. AGE (In years last birthday) <u>1 day</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Kramer Robert</u>		14. MOTHER'S MAIDEN NAME <u>M^{rs} Connell, Elizabeth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease - type not defined</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>30 1/4 hours.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-16, 1956, to 8-17, 1956</u> , that I last saw the deceased alive on <u>8-16, 1956</u> , and that death occurred at <u>12:21 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6811 Riggs Rd., Hyattsville, Md.</u> DATE SIGNED <u>8-17-56</u>			
ACTUAL SIGNATURE <u>Mary K. L. Sartwell</u>		M.D. <u>6811 Riggs Rd., Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) _____		DATE _____	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 1956</u>	22c. NAME OF CEMETERY OR CREMATION <u>Prince Georges</u>	22d. LOCATION (City, town, or county) (State) <u>Cherry</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mary K. L. Sartwell</u>		24. RECEIVED BY REGISTRAR (Type) <u>R. H. Zedrich</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

SEP 4 1956

RECEIVED
SEP 4 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8580
CERTIFICATE OF DEATH

08588
245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. LENGTH OF STAY IN 1b 22 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 3100 Webster Street				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
				d. STREET ADDRESS 3100 Webster Street			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RAYMOND HARRY KRAMER				4. DATE OF DEATH Month August Day 13th Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 27/1902	
				9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Naval Brd. Lab.		11. BIRTHPLACE (State or foreign country) Frackville, Penna.	
13. FATHER'S NAME Harry A. Kramer				14. MOTHER'S MAIDEN NAME Emma Kramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Ruth I. Kramer, 3100 Webster St. Mt. Rainier	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Thrombosis &							
DUE TO CORONARY Heart DISEASE							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HAD Surgical GRAFT Aorta 6/27/56 For Thrombosis of							
TERMINAL AORTA AT GARFIELD HOSPITAL							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No Injury			
20c. TIME OF INJURY Month, Day, Year Hour 2:40 a. m. 8/13/1956 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Auburn, Penna.		(County) (State)	
21. I certify that I attended the deceased from MAY 26, 1956 , to August 13, 1956 , that I last saw the deceased alive on August 12, 1956 , and that death occurred at 2:40 p. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ray Brown, M.D.				ADDRESS (Street, city or town, state) 1726 EYE ST. NW.			
DATE SIGNED 8/13/56							
PHYSICIAN'S NAME (Type) RAY BROWN, MD				WASH. 6, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16/1956		22c. NAME OF CEMETERY OR CREMATORY Independent Church of God Cemetery		22d. LOCATION (City, town, or county) (State) Auburn, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE (Type) W.W. Chambers Co. Riverdale, Md.						24a. REC'D BY REGISTRAR DATE Aug 17 1956	
						24b. REGISTRAR'S SIGNATURE Ms. Jas. Severe Deputy	

THIS HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAY 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8604

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cheverly Nursing Home		d. STREET ADDRESS 3004 Lake Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary C. Kruss		4. DATE OF DEATH Month Day Year Aug. 9, 1956 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1897
9. AGE (In years last birthday) 77 1/2 yrs.		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady Retired		10b. KIND OF BUSINESS OR INDUSTRY Shoe	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ferdinand Kruss		14. MOTHER'S MAIDEN NAME Mary Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Bertha Kruss		Address 3004 Lake Ave. Cheverly, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Congestive heart failure (b) Anteroseptal DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary vascular associated with left hemiparesis Jan 1954			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5 Jan, 1954, to 9 Aug, 1956, that I last saw the deceased alive on 7 Aug, 1956, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John Kehoe		M.D.	
PHYSICIAN'S NAME (Type) Dr. John Kehoe		3404 Cheverly Ave. Cheverly, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13/56	22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	22d. LOCATION (City, town, or county) (State) Cincinnati, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Ludman		ADDRESS 300 4th St. N.E. D.C.	
24a. REC'D BY REGISTRAR Aug. 13-56		24b. REGISTRAR'S SIGNATURE Carrie Campbell	

RECEIVED

AUG 16 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

18590

8642

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum				c. LENGTH OF STAY IN 1b 8 Yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5806 Riggs Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THELMA Middle FANT Last LANGSTON				4. DATE OF DEATH Month August Day 21 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 8, 1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Ga.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CLAUDE LANGSTON				14. MOTHER'S MAIDEN NAME GERTRUDE WEBB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Father Address 434 South Green Street Dalton, Ga.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral compression DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous intracranial hemorrhage DUE TO (c) Essential hypertension,							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED 21 August 1956			
EXAMINER'S NAME (Type) JOHN T. MALONEY M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/56		22c. NAME OF CEMETERY OR CREMATORY West Hill Cemetery		22d. LOCATION (City, town, or county) (State) Dalton Ga.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR Aug 22 1956		24b. REGISTRAR'S SIGNATURE <i>Joe Severe</i>	

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BUREAU V. E.

AUG 22 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>8 Cheverly</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George's Gen. Hosp.</i>				d. STREET ADDRESS <i>36 "P" Ridge Rd.</i>			
3. NAME OF DECEASED (Type or print) First <i>Baby</i> Middle <i>Boy</i> Last <i>Largent</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>20</i> Year <i>1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 19, 1956</i>	9. AGE (In years, lost birthday) <i>1</i> yrs. <i>1</i> month <i>1</i> day <i>1</i> hour <i>1</i> min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cheverly, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Largent, Kenneth</i>				14. MOTHER'S MAIDEN NAME <i>Norma Jane Jackson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>atelectasis</i> DUE TO <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>atelectasis</i> DUE TO (c) <i>Pneumonia</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVAL BETWEEN ONSET AND DEATH</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Aug 14, 1956</i> to <i>Aug 20, 1956</i> that I last saw the deceased alive on <i>Aug 20, 1956</i> and that death occurred at <i>3:30 PM</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>5301 Hamilt - 58, Hyattsville</i>				DATE SIGNED <i>8/21/56</i>			
ACTUAL SIGNATURE <i>John A. Perkins</i> M.D.				DATE SIGNED <i>8/21/56</i>			
PHYSICIAN'S NAME (Type)				DATE SIGNED <i>8/21/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Aug 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Prince George's Gen Hosp Cheverly Md</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Perkins</i> ADDRESS <i>1000 Columbia</i>				24a. REC'D BY REGISTRAR <i>DATE</i>		24b. REGISTRAR'S SIGNATURE <i>A. H. Hedrick</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 4 1956

RECEIVED

Item 12, Sec. Birth Cert.

CERTIFICATE OF DEATH

Reg. Dist. No.

8696

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>36 "P" Ridge Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Girl</u> Middle <u>Largent</u> Last <u>Largent</u>		4. DATE OF DEATH <u>Aug. 20, 1956</u> Month <u>Aug.</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1956</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cheverly, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Largent Kenneth</u>		14. MOTHER'S MAIDEN NAME <u>Norma Jane Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. W. G. G.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
DUE TO Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atelectasis
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atelectasis
INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 14, 1956, to Aug 20, 1956, that I last saw the deceased alive on Aug 20, 1956, and that death occurred at 3:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE J. W. G. G. M.D. 5301 Hamilton St. Hyattsville ADDRESS (Street, city or town, state) DATE SIGNED 8/21/56

PHYSICIAN'S NAME (Type) J. W. G. G.

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

22b. DATE THEREOF Aug 1956

22c. NAME OF CEMETERY OR CREMATORY Prince Georges Gen Hosp Chesley Md

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn ADDRESS Chesley

24a. REC'D BY REGISTRAR SEP 1 1956

24b. REGISTRAR'S SIGNATURE H. W. Penn

BOULEAU V. S.

1854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

130

8570

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cool Springs and Adelphi Rd.				d. STREET ADDRESS 3426 Tulane Drive			
3. NAME OF DECEASED (Type or print) First Robert Middle Merrick Last Leonnig				4. DATE OF DEATH Month Aug. Day 27 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1934	9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min.		IF UNDER 24 HRS. Hours 22 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Asst.		10b. KIND OF BUSINESS OR INDUSTRY Golf Club		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leo John Leonnig				14. MOTHER'S MAIDEN NAME Marion Kent Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-44-3295		17. INFORMANT John Leonnig, Rt. 1, Landover, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO self inflicted gunshot wound of head. Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost. (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Same as 18 B.					
20c. TIME OF INJURY Month, Day, Year Hour 8-21-56 a. m. 8-21-56 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) (County) (State) College Park, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED August 27, 1956			
EXAMINER'S NAME (Type or print) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 8/30/56		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Wheaton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasche Sons H. Gattouille Inc				24a. REC'D BY REGISTRAR AUG 31 1956		24b. REGISTRAR'S SIGNATURE John D. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 1 1951

RECEIVED

DEPUTY MEDICAL EXAMINER: This certificate should be executed in 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08594	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 231	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 5412 56th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Roxy Middle Ralph Last Malpiede					4. DATE OF DEATH Month August Day 10 Year 1956						
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1900		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman				10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Colorado			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 521-05-9642		17. INFORMANT Address Elizabeth Malpiede; Same address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. 267X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE John T. Maloney M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			August 11, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 14, 1956		22c. NAME OF CEMETERY OR CREMATOR Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va Colmar Manor Md.					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.						24a. REC'D BY REGISTRAR Aug 13 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick			

ROMANOV V. S.

1900

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8698
CERTIFICATE OF DEATH

18595

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gov. Hosp.</u>		e. STREET ADDRESS <u>4305-40th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Eva</u> First <u>Mark</u> Middle <u>ward</u> Last		4. DATE OF DEATH <u>August 16, 1956</u> Month <u>August</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1885</u> 9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
13. FATHER'S NAME <u>Edmond Codrick</u>		14. MOTHER'S MAIDEN NAME <u>Ada Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Blanche McClary</u>		2515 Hughes Road Adelphi, Md. Hyatts., P. O.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Cerebral Hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>40</u> , to <u>Aug. 16</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug. 16</u> , 19 <u>56</u> , and that death occurred at <u>6:35</u> M, from the causes and on the date stated above. P. ADDRESS (Street, city or town, state) <u>Mt. Rainier, Md.</u> DATE SIGNED <u>8/16/56</u> ACTUAL SIGNATURE <u>C. C. Hageage</u> M.D. <u>Mt. Rainier, Md.</u> PHYSICIAN'S NAME (Type) <u>C. C. Hageage M.D.</u> <u>Mt. Rainier, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>20 Aug. 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Pr. Geo. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 20 1956</u> DATE	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8699

CERTIFICATE OF DEATH

18596

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>La Plata</u>	
3. NAME OF DECEASED (Type or print) <u>Elsie</u> First <u>Morie</u> Middle <u>Martin</u> Last		4. DATE OF DEATH <u>Aug 15</u> 19 <u>56</u> Month <u>Aug</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23, 1928</u> 27 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.W.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elsie P. McFahan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph B. Martin</u> Address <u>La Plata, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CA OF BREAST</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>49 hrs.</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11.</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 14</u> , 19 <u>56</u> , to <u>Aug. 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 15</u> , 19 <u>56</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John O. Ford</u>		ADDRESS (Street, city or town, state) <u>7200 MARLBORO RD.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOHN O. FORD</u>		<u>DISTRICT HEIGHTS, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Ignace</u>	22d. LOCATION (City, town, or county) (State) <u>Chesapeake Point Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wendell J. La Plata</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>8/21/56</u>	24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>

2

1956

1956-1957

8531

CERTIFICATE OF DEATH

08597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT RAINIER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT RAINIER</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>3505 BUNKER HILL RD</u>		d. STREET ADDRESS <u>3505 BUNKER HILL RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles William May</u>		4. DATE OF DEATH Month Day Year <u>Aug 17 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 4, 1895</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STATIONARY ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>18-05-0801 MANASSAS VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>MANASSAS VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MAY</u>		14. MOTHER'S MAIDEN NAME <u>WHITMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>HELEN R. MAY WIFE</u> Address <u>3505 BUNKER HILL RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO 5 years (c) <u>Generalized Arteriosclerosis</u> DUE TO 7 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT 1952</u> to <u>Aug 17, 1956</u> that I last saw the deceased alive on <u>Aug. 9, 1956</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comrau</u> M.D.		ADDRESS (Street, city or town, state) <u>3505 Bunker Hill Rd. Prince Georges Md.</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMRAU</u>		DATE SIGNED <u>8/17/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery, Baltimore, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley Funeral Home</u> ADDRESS <u>3200-R.I. Ave. Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR <u>Gas. Surgeon</u> DATE <u>8/21/56</u>	
24b. REGISTRAR'S SIGNATURE			

RECEIVED

AUG 21 1950

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 days after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8610 CERTIFICATE OF DEATH

08599
245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>DC.</u> b. COUNTY <u>47</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC - SE.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>601 Galveston Pl SE.</u>			
3. NAME OF DECEASED (Type or print) <u>EVELYN</u> First Middle Last <u>C M KAIN</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-93</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. AGE UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Mass</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Isaac Calvin Capeland</u>				14. MOTHER'S MAIDEN NAME <u>Adella Jane Niles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or years of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>Record Office</u> Address <u>70 Hard</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corbexin, heart failure</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>metastatic carcinoma</u> DUE TO (c) <u>carcinoma of colon</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u> <u>18 mo</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 11, 1956</u> , to <u>Aug 14, 1956</u> , that I last saw the deceased alive on <u>Aug 14, 1956</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. F. Wilkinson</u> M.D.				ADDRESS (Street, city or town, state) <u>4408 QUEENSBURY ROAD</u>			
PHYSICIAN'S NAME (Type) <u>R. F. WILKINSON</u>				DATE SIGNED <u>8/14/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				22b. DATE THEREOF <u>8/15/1956</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>SUITLAND - RICO CO, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamberlo</u> ADDRESS <u>RIVERDALE, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 15 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Lavers</u>							

RECEIVED

AUG 16 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

18600
231

8611

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2601 Cheverly Ave</u>		d. STREET ADDRESS <u>2308 Cheverly Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>ELSIE</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAR TON MACHINE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? schenke</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs Elsie Buddington</u> Address <u>Springfield Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>400.0</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RHEUMATIC AND ARTERIOSCLEROTIC</u> DUE TO <u>HEART DISEASE</u> (c) <u>15 YEARS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1951</u> to <u>Aug 10, 1956</u> that I last saw the deceased alive on <u>Aug 4, 1956</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Comcau</u> M.D.		ADDRESS (Street, city or town, state) <u>3303 Ring St. Mt Rainier Md</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMCAU</u>		DATE SIGNED <u>8/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 14, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u></u>	
24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrich</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 13 1956

ROBERT A. BROWN

1956

1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08601

Reg. Dist. No. 282

8643

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosaryville c. LENGTH OF STAY IN 1b Transient d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 301				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Bergen c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fair Lawn d. STREET ADDRESS 23-09 Berkshire Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Francis Last Moran			4. DATE OF DEATH Month August Day 23 Year 19 56				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH November 24, 1905		9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Assistant 10b. KIND OF BUSINESS OR INDUSTRY Petroleum 11. BIRTHPLACE (State or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George W. Moran			14. MOTHER'S MAIDEN NAME Agnes Gaines				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 091-03-5804		17. INFORMANT Doris C. Moran Address same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Hemorrhage and shock IMMEDIATE CAUSE (a) DUE TO Fracture of the skull, crushed chest, fracture and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. dislocation of the cervicle vertebrae DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) object Occupant of a automobile that ran off the road and struck a fixed					
20c. TIME OF INJURY Month, Day, Year Hour 12:30 o. m. 8/23/ 56		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 301 20f. (City or town) Rosaryville (County) P. G. (State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) James I. Boyd			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 23, 1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cemetery			
22d. LOCATION (City, town, or county) Totowaborough		(State) New Jersey					
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons			ADDRESS Hyattsville Maryland.		24a. REC'D BY REGISTRAR DATE 8/27/56		
24b. REGISTRAR'S SIGNATURE 							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

5.11.11

1956

11/11/11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G202

8612

CERTIFICATE OF DEATH

08602

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosely, Ind.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danham</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>Nasal Prost Spring</u>	
3. NAME OF DECEASED (Type or print) <u>Harold W Newkirk</u>		4. DATE OF DEATH <u>Aug. 25, 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/24/98</u>
9. AGE (In years) <u>58</u> yrs		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>7</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service manager Mandel Chevrolet</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Detroit Michigan U.S.A</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank Newkirk</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Walters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>221-01-7997</u>	
17. INFORMANT <u>Hospital Records Cheverly, Ind</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>5</u> p. m. 19 <u>56</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>48</u> , to <u>8-25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-25</u> , 19 <u>56</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Bertz, M.D.</u>		DATE SIGNED <u>8-26-56</u>	
PHYSICIAN'S NAME (Type) <u>H. Hoffmann</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Gasch-Sosa Hyattsville Ind</u>		24. REC'D BY REGISTRAR <u>8/28/56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>J. H. Hedrick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL

1956

CONFIDENTIAL

RECEIVED

AUG 14 1956

STAN Y. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 8614 8614 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

88614

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Don</u> Middle <u>Carlos</u> Last <u>Piper</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21 Sept. 1901</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photo Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Duncan McArthur Piper</u>			
14. MOTHER'S MAIDEN NAME <u>Coza Lee Turnell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Hospital Records</u> Address <u>Cheverly, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO <u>Bronchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 mos</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1957, to <u>Aug 6</u> , 1956, that I last saw the deceased alive on <u>Aug 5</u> , 1956, and that death occurred at <u>2,20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Bmeau</u>				ADDRESS (Street, city or town, state) <u>3503 Perry Rd Rainier Md.</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BMEAU</u>				DATE SIGNED <u>8/6/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/9/56</u>		<u>Union Star Cemetery</u>		<u>Union Star Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasche Sons</u>				ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR <u>G. G. 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>			

DOUGLAS A. B.

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8644

CERTIFICATE OF DEATH

08605

Reg. Dist. No.

143

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #6 Prospect Hill Road				d. STREET ADDRESS #5 Prospect Hill Rd.			
3. NAME OF DECEASED (Type or print) First John Middle Louis Last Poats				4. DATE OF DEATH Month Aug. Day 4 Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/1872	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bowling Green, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Louis L. Poats				14. MOTHER'S MAIDEN NAME Mary Alice Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT #6 Prospect Hill Rd. Ruth A. Snell-Glenn Dale, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 220.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH minutes years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Early Pneumonia - left						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. , 19 51 , to Aug 4 , 19 56 , that I last saw the deceased alive on Aug 3 , 19 56 , and that death occurred at 10:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. James Kurtz M.D.				ADDRESS (Street, city or town, state) RFD Bowie Md DATE SIGNED 8/4/56			
PHYSICIAN'S NAME (Type) H. James Kurtz				ADDRESS RFD Bowie Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/7/56		22c. NAME OF CEMETERY OR CREMATORY Lakewood Cemetery		22d. LOCATION (City, town, or county) (State) Bowling Green, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D.C.				24a. REC'D BY REGISTRAR DATE 8 1956		24b. REGISTRAR'S SIGNATURE Mrs John Zingling	

MEDICAL CERTIFICATION

1

M



BUREAU V. S.

AUG 8 1956

U.S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8615 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08606
Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 155 9th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel Porter				4. DATE OF DEATH Month August Day 30 Year 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1923		9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Booker W. Parker				14. MOTHER'S MAIDEN NAME Estelle Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (b) General anesthesia given for bronchoscopy (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic carcinoma with generalised carcinomatosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		August 30, 1956	
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF 9/4/56		22c. NAME OF CEMETERY OR CREMATORY Folk, N.E. Church		22d. LOCATION (City, town, or county) (State) Anne arundel Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Snowden Rockwell				24a. REC'D BY REGISTRAR DATE 6 1956		24b. REGISTRAR'S SIGNATURE R. H. Edwards	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 6 1956

RECEIVED

8645

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Aquasco</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>PG</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Aquasco</u> STREET ADDRESS (If rural, give location) <u>Rural - Aquasco</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>CHILVERT LEE POSEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 24 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr. 29, 1956</u>	9. AGE last birthday yrs. <u>3</u> mos. <u>26</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Prince Geo Co - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ARTHUR POSEY</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE DOUGLAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <u>Mother - Louise Douglas - Aquasco Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Post Decease Inanition</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Infectious Decease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____				5 days 2 weeks			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Aug 8</u> , 19 <u>56</u> , to <u>Aug 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 22</u> , 19 <u>56</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Vadeh M. Serin</u> M.D.				ADDRESS (Street, city, town, state) <u>Aquasco, Md</u>		DATE SIGNED <u>Aug 24, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>8-24-56</u>	NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		LOCATION (City, town, or county) (State) <u>Bryantown Md.</u>			
24. REC'D BY REGISTRAR DATE <u>8/28/56</u>	REGISTRAR'S SIGNATURE <u>A. W. Harch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Washington Md.</u>		

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8576

CERTIFICATE OF DEATH

Reg. Dist. No.

88608

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md c. LENGTH OF STAY IN 1b 3 Months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5505 43th Place,.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. d. STREET ADDRESS 5505 43th Place, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Jerome Powers		4. DATE OF DEATH Aug 18, 1956.	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 3, 1880
9. AGE (In years lost birthday) 76 yrs		IF UNDER 1 YEAR: Months 76 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY Wash Sanitary Comm	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Jerome Powers		14. MOTHER'S MAIDEN NAME Mamie Reilly	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Myrtle Powers	
17. INFORMANT Myrtle Powers		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Diabetes Mellitus. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus. (c) Diabetes Mellitus.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 3, 1880 to 8-18-56 that I last saw the deceased alive on 8-18-56 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE A Deitz M D		DATE SIGNED Hyattsville Md 8-20-56	
PHYSICIAN'S NAME (Type) A Deitz M D		Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/21/56	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR AUG 22 1956		24b. REGISTRAR'S SIGNATURE Gasch's Sons	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 22 1950
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6201

8616

CERTIFICATE OF DEATH

Reg. Dist. No.

08619 231

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hyattsville</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Hosp</u>				d. STREET ADDRESS <u>4108 Kennedy Bt.</u>			
3. NAME OF DECEASED (Type or print) First <u>STEPHEN</u> Middle <u>W.</u> Last <u>PRICE</u>				4. DATE OF DEATH Month <u>AUG</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-187</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Design Engineer Naval Gun Factory</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Design Engineer Naval Gun Factory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>John J. Price</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Ethel S Price</u> Address <u>Hyattsville Md</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO <u> </u> (c) <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 3</u> , 19 <u>56</u> , to <u>Aug 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>56</u> , and that death occurred at <u>3:31 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arnold A. Lear</u> M.D. <u>4314 Gallatin St</u>				ADDRESS (Street, city or town, state) <u>Hyattsville, Md</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD A. LEAR, MD</u>				DATE SIGNED <u>8-5-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Susch</u> ADDRESS <u>Hyattsville Md</u>				24. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 7 1956</u>			
24b. REGISTRAR'S SIGNATURE <u> </u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

BUREAU OF

1906

RECEIVED

8617

CERTIFICATE OF DEATH

08610

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landoner</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Proctor</u> Last <u>Proctor</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/91</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHAS. CO. M.D.</u>	
11. BIRTHPLACE (State or foreign country) <u>CHAS. CO. M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>ALBERT PROCTOR</u>		14. MOTHER'S MAIDEN NAME <u>JENNY PROCTOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HERMAN PROCTOR</u>		Address <u>1420 N. AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11:30</u> , 19 <u>56</u> , to <u>11:30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Stewart</u> M.D.		ADDRESS (Street, city or town, state) <u>5802 Eastmore Ave. Synterville Md.</u>	
PHYSICIAN'S NAME (Type) <u>John J. Stewart</u>		DATE SIGNED <u>Aug 29 1956</u>	
22a. BURIAL CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE OF BURIAL <u>8-29-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace</u>	22d. LOCATION (City, town, or county) (State) <u>Open, Hill Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stewart</u>		24a. REC'D BY REGISTRAR <u>Aug 29 1956</u>	
ADDRESS <u>304 N. E. St.</u>		24b. REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 29 1956

AUG 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

8618

CERTIFICATE OF DEATH

08611

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY P. G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.			
c. LENGTH OF STAY IN 1b 7 Days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 5906 Riverside Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last (Baby Boy) John Emmett Reese				4. DATE OF DEATH Month Day Year 8 13 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-6-56	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
7		7		4		1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None-Infant				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Reese				14. MOTHER'S MAIDEN NAME Leah Edith Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give no. or date of service) None		17. INFORMANT Address William H. Reese 5908 Riverside Dr. Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity 776 x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/6 , 19 56 to August 13, 1956 , that I last saw the deceased alive on August 13 , 19 56 , and that death occurred at 9:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leon R. Levitsky M.D. 4300 Kelywood Dr. Mt Rainier, Md 8/13/56							
ACTUAL SIGNATURE Leon R. Levitsky							
PHYSICIAN'S NAME (Type) Leon R. Levitsky							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17/1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.				24. REC'D BY REGISTRAR DATE Aug 20 1956			
24b. REGISTRAR'S SIGNATURE A. W. Hedrick							

BUREAU V. 3

AUG 20 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08612

8646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Prince George's				STATE Maryland COUNTY Pr. Geo's. Co.			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Rural		10 Yrs.		TOWN Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				6319- Oaklawn Road S. E.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
DOLLIE OLIVIA REID				August 1st. 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widowed	Dec. 29-1874	82 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Domestic		Washington, D.C.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Handing				Mary O. Harper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no				William C. Ried 6319- Oaklawn Rd. S.E.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						6- Months	
IMMEDIATE CAUSE (A)							
Congestive Heart Failure							
ANTECEDENT CAUSE(S) DUE TO (B)						5 Days	
Obstructive Jaundice							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						5 Yrs.	
Diabetes Mellitus							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 51, 1951, to August 1, 1956, that I last saw the deceased alive on July 29, 1956, and that death occurred at 3 A.M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Anna Cygne Todd				August 1-1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial				Cedar Hill Cemetery		Suitland, Maryland.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
AUG 2 1956		A. H. Hedricks		[Signature]		1661- Good Hope RD. SE. Washington, D.C.	

RECEIVED

AUG 2 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08613

8619

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General Hospital</u>				e. STREET ADDRESS <u>Inglewood farm Box 25</u>			
3. NAME OF DECEASED (Type or print) First <u>Maynard</u> Middle <u>Roberts</u> Last <u>Roberts</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 March 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Tobacco)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				13. FATHER'S NAME <u>T. O. W. Roberts</u>			
14. MOTHER'S MAIDEN NAME <u>Alice Carter</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Helen Roberts</u> Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Tosis Lung</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Primary Origin Undetermined)</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aortic Stenosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>8/16</u> , 19 <u>56</u> , to <u>8/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/17/56</u> , 19 <u>56</u> , and that death occurred at <u>1:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Suit Ritchie</u> M.D. <u>7005 Ritchie Road S.E. Wash. 27 D.C.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>W. Suit Ritchie</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Collington, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros-Upper MARILAND</u>				24a. REC'D BY REGISTRAR <u>MD.</u>		24b. REGISTRAR'S SIGNATURE <u>R. N. Hedrich</u>	

RECEIVED
JUN 28 1956
BUREAU V. B.

8620

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, 28</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges General Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Rose</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1895</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHILDRENS WEAR</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL</u>		14. MOTHER'S MAIDEN NAME <u>GOLDIE HERSHKOWITZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-12-0345</u>	
17. INFORMANT <u>LILLIAN ROSE</u>		Address <u>5500 Silver Hill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Chronic arteriosclerotic myocarditis</u> DUE TO (c) <u>1 yr</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1</u> , 1956, to <u>Aug 10</u> , 1956, that I last saw the deceased alive on <u>Aug 9</u> , 1956, and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5480 Silver Hill Rd SE</u> DATE SIGNED <u>8/10/56</u>			
ACTUAL SIGNATURE <u>PAUL C VAN NATA</u> M.D. <u>Washington 28 DC</u>		PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATA</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Aug. 12, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Can.</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gresham Funeral Home - 4217-9</u>		24. REC'D BY REGISTRAR <u>Aug 14 1956</u>	
ADDRESS <u>4217-9</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	

RECEIVED

AUG 14 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
8647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Items 22 c.d. film 8-20-56 et										
Reg. Dist. No. 88615										
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City			c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3702 41st Avenue					d. STREET ADDRESS 3702 41st Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Francis De Sales Sauer					4. DATE OF DEATH Month Day Year August 6th 1956					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27, 1898		9. AGE (In years last birthday) 57 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Gun Fac.			11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph A. Sauer					14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mary B. Sauer, Same address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE John T. Maloney M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John T. Maloney, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 8, 1956					22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gascher Sons Hyattsville, Md					24. REC'D BY REGISTRAR Aug 9 1956		24b. REGISTRAR'S SIGNATURE A. H. Hedrick			

RECEIVED
AUG 9 1950
BUREAU A

8621

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince George General Hosp</u>				d. STREET ADDRESS <u>2807 Nicholson ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Schneibalk</u> Last <u>Schneibalk</u>				4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 9, 1956</u>	
9. AGE <u>44</u> years (lost birthday) <u>yn</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State of foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>VICTOR SAMUEL SCHNEIBALK</u>				14. MOTHER'S MAIDEN NAME <u>GERALDINE BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>Hosp. Records</u> Address <u>_____</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>1.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity (20 week gestation)</u> (c) <u>Premature separation of placenta</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 5 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/9/56</u> , 19 <u>56</u> , to <u>8/9/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/9/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert J. Friedel</u>				ADDRESS (Street, city or town, state) <u>6826 Riggs Rd, Hyattsville, Md</u>			
PHYSICIAN'S NAME (Type) <u>HERBERT J. FRIEDEL</u>				DATE SIGNED <u>Aug. 9, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cem. Glen Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzane G. Pons</u> ADDRESS <u>3501-14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>_____</u> DATE <u>1</u>		24b. REGISTRAR'S SIGNATURE <u>_____</u>	

TO HOSPITAL ■ ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG. 14 1956

DEAU V. S.

8622

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

JOHN A. BROWN

1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68618

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill c. LENGTH OF STAY IN TB 19 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4309 Silver Hill Road				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill d. STREET ADDRESS 4309 Silver Hill				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Theresa First Middle Last Serra				4. DATE OF DEATH Month Day Year Aug 9 1956									
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1883		9. AGE (In years last birthday) 73 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Foppiano						14. MOTHER'S MAIDEN NAME Jessie							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.				17. INFORMANT Elvera M Hasler Address same # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE James T. Boyd M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED Aug 9, 1956	
EXAMINER'S NAME (Type) James T. Boyd						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Aug 13, 1956				22c. NAME OF CEMETERY OR CREMATORY New Cathedral				22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE J. Williams Lee's Sons Co. 300 N. 1st St.						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Carrie Campbell					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

AUG 16 1956

RECEIVED

Received by the
Director of the
Bureau of the
Census

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8649 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08619

Reg. Dist. No.

247

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL) Suitland c. LENGTH OF STAY IN 1b Transit d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4002 Silver Hill Rd.				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 d. STREET ADDRESS 811 Quincy St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MABLE MARIE SIMPSON First Middle Last				4. DATE OF DEATH Aug. 30 1956 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11 Oct. 1894 9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Standard Coffee Co.		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wallace Clark				14. MOTHER'S MAIDEN NAME Sarah ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 478-036-510		17. INFORMANT Eilene Johnson 1319 S. 4th Street (Daughter) Falls Church, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (b) Cardio Vascular Renal Disease (c) Cardio Vascular Renal Disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James I. Boyd</i> EXAMINER'S NAME (Type) James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/3/56		22c. NAME OF CEMETERY OR CREMATORY OAKLAND Cemetery		22d. LOCATION (City, town, or county) (State) CENTERVILLE IOWA	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS ADDRESS HEATTSVILLE, Md.				24a. REC'D BY REGISTRAR DATE 7 1956		24b. REGISTRAR'S SIGNATURE <i>Care Campbell</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 7 1956

BUREAU V. B.

8650

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - FORESTVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Forestville</u>			
c. LENGTH OF STAY IN 1b <u>1 month</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7650 Marlboro Pike, Wash 28 SE</u>			
d. STREET ADDRESS <u>7650 - Marlboro Pike SE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>LEE</u> Last <u>SMOOTH</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 28, 1870</u>	
9. AGE (In years, last birthday) <u>86</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>21</u> Days <u>21</u> Hours <u>21</u> Min <u>21</u>		11. BIRTHPLACE (State or foreign country) <u>Pr. Geo. County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
13. FATHER'S NAME <u>Daniel C. Lowe</u>				14. MOTHER'S MAIDEN NAME <u>Georgiana Stone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Ms. S. Lancaster - 7650 Marlboro Pike SE Wash 28 SE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS UNDERLYING IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastases</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>55</u> , to <u>Aug 21</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug 21</u> , 19 <u>56</u> , and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				DATE SIGNED <u>8/21/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661 - 16th St NE Wash D.C.</u>				24a. REC'D BY REGISTRAR <u>16</u>		24b. REGISTRAR'S SIGNATURE <u>R. W. Hedrick</u>	

BUREAU V. 1

3 1936

RECEIVED

8623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 7204 Bowdoin Avenue		
3. NAME OF DECEASED (Type or print) Silas Flannery Speaks			4. DATE OF DEATH August 19, 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1922		9. AGE (In years last birthday) 34 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Electronics		11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME John Speaks			14. MOTHER'S MAIDEN NAME Alma Wright		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT mother Address Alma Speaks, wife, Same address.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Obstruction of larynx DUE TO (c) Retropharyngeal abscess with edema of larynx.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 19, 1956	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 8/24/56	22b. DATE THEREOF Engle Funeral Home	22c. NAME OF CEMETERY OR CREMATORY Hazard		22d. LOCATION (City, town, or county) (State) Ky.	
23. FUNERAL DIRECTOR'S SIGNATURE F. GASCH'S SONS ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR 8/27/56		24b. REGISTRAR'S SIGNATURE A.W. Hedrick	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08622

8577

CERTIFICATE OF DEATH

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4005 Kennedy Street				d. STREET ADDRESS 4005 Kennedy Street			
3. NAME OF DECEASED (Type or print) First Virginia Middle Lee Last Sprouse				4. DATE OF DEATH Month Aug. Day 7 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 April 1865		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard Mason Bell				14. MOTHER'S MAIDEN NAME Sarah Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO. None..		17. INFORMANT Alice Gallagher Address Same add as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia							2m
DUE TO 551X							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Cerebral Vascular Accident							3 week
DUE TO							
(c) Atherosclerosis							?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May , 1956, to Aug 7 , 1956, that I last saw the deceased alive on July 29 , 1956, and that death occurred at AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon W. Kelley				ADDRESS (Street, city or town, state) 6124-41st Ave. Hyattsville Md			
PHYSICIAN'S NAME (Type) Gordon W. Kelley				DATE SIGNED 8/7/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/1956		22c. NAME OF CEMETERY OR CREMATORY Methodist - Protestant		22d. LOCATION (City, town, or county) (State) Alexandria Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR Aug 7 1956	
				24b. REGISTRAR'S SIGNATURE Mrs Jas Severa			

BUCKLEY A. E.

AUG 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1207 N. Street, N.W.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Stewart Last				4. DATE OF DEATH Month August Day 27 Year 19 56			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 18, 1913		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Harvey Oliver, Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracranial hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebrovascular accident (c) Essential hypertension DUE TO cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> August 28, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept-1-1956		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.				ADDRESS 901 3rd Street, S. W.		24a. REC'D BY REGISTRAR Aug 31 1956	
				24b. REGISTRAR'S SIGNATURE A. H. Hedrich			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 5

AUG 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8651 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08624

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cornoddy Hills</u> c. LENGTH OF STAY IN 1b <u>10 years</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cornoddy Hills</u> d. STREET ADDRESS <u>303-72nd Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Richard Stone</u> First Middle Last		4. DATE OF DEATH <u>Aug 21 1956</u> Month Day Year			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 1884</u>	9. AGE (In years last birthday) <u>71</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Researcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mary Stone, same as #2</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hanging</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Hanged self by neck with a piece of rope.</u>			
20c. TIME OF INJURY Month, Day, Year <u>Hour 4:30 p.m. 3-21-1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Cornoddy Hills</u>		20g. (County) <u>Prince Georges</u>		20h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Bond</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Aug 22, 1956</u>	
EXAMINER'S NAME (Type) <u>James I. Bond</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>	
22d. LOCATION (City, town, or county) <u>MD</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Adams</u>			
24a. REC'D BY REGISTRAR <u>DATE 8/28/56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8571

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4904 NIAGARA ROAD</u>				d. STREET ADDRESS <u>4904 Niagara Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Herbert</u> Last <u>Stotler</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1925</u>	9. AGE (In years last birthday) <u>31</u> yrs	IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk. Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Southern Pacific</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sina Stotler</u>				14. MOTHER'S MAIDEN NAME <u>Etta Widmyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 7-2-43-2-24-46</u>		16. SOCIAL SECURITY NO. <u>236-28-5896</u>		17. INFORMANT Address <u>Mrs Darnis Stotler 4904 Niagara Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of Left Testicle</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u> <u>9 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. j. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> 1955, to <u>27 July</u> 1956, that I last saw the deceased alive on <u>27 July</u> 1956, and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7315 Landoner Rd Hyattsville Md 1956</u>							
ACTUAL SIGNATURE <u>Thos M Hutchins</u> M.D.				PHYSICIAN'S NAME (Type) <u>THOMAS M HUTCHINS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Aug 3/1956</u>		<u>ARLINGTON NATL Cem</u>		<u>ARLINGTON VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co., Alexandria, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Aug 3-1956</u>		24b. REGISTRAR'S SIGNATURE <u>John D Smith</u>	

BUREAU V. S.

APR 19 1956

RECEIVED
U.S. DEPARTMENT OF JUSTICE

100-101

8625

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08626

Item 9, Film G201, 8/23/56 bh CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 3107 Lake Ave	
3. NAME OF DECEASED (Type or print) First Middle Last Lella Surratt		4. DATE OF DEATH Month Day Year Aug 16 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Aug. 1873
9. AGE (in years last birthday) yrs 82		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? S A	
13. FATHER'S NAME William H. Hubbard		14. MOTHER'S MAIDEN NAME Jane E. Saner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Agnes Humphrie		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 weeks</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1955, to <u>Aug 16</u> , 1956, that I last saw the deceased alive on <u>Aug 15</u> , 1956, and that death occurred at <u>1:50 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Daniel (Dr.)</u>		ADDRESS (Street, city or town, state) <u>3503 Jenny St</u>	
PHYSICIAN'S NAME (Type) <u>William Daniel (Dr.)</u>		DATE SIGNED <u>8/16/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6/18/56</u>	<u>N. Wilkesboro, N.C.</u>	<u>N. Wilkesboro, N. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Lee & Sons</u>		24a. REC'D BY REGISTRAR <u>Washington D.C. AUG 20 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Amelia D. Doney</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 4 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 20 1956

BUREAU V. S.

8652

CERTIFICATE OF DEATH

Reg. Dist. No. 731

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>PRINCE GEORGES</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEO.</u>			
CITY (if outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>RURAL - BRANDYWINE</u>		<u>20 yrs</u>		TOWN <u>RURAL - BRANDYWINE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u> (Middle) <u>D.</u> (Last) <u>SUTHARD (MRS.)</u>				(Month) <u>Aug.</u> (Day) <u>8,</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>M</u>	<u>April 8, 1885</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Pennsylvania</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>DANIEL ALTFATHER</u>				<u>MALINDA WALKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>				<u>Husband - L.H. Brandywine</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
X IMMEDIATE CAUSE (A) <u>Chronic Myocardial Failure</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertension</u>						<u>3-4 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u>						<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Cholecystitis</u>						<u>2 yrs</u>	
19. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>Jan 24, 1955</u>		<u>Chronic Cholecystitis</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Jan 22, 1955</u> to <u>Aug 8, 1956</u> , that I last saw the deceased alive on <u>July 29, 1956</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Valeh M. Seem</u>		<u>A. J. Seem</u>		<u>1661 - Good Hope Rd</u>		<u>8/8/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 10-56</u>		<u>Denton Cemetery</u>		<u>Denton Md</u>	
24. RECD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>AUG 9 1956</u>		<u>John F. Seem</u>		<u>Simmons Bros</u>		<u>1661 - Good Hope Rd</u>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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7 6 500

7 6 500

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8626

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

186281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. LENGTH OF STAY IN <u>Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Southall</u>			
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's Sanatorium</u>				d. STREET ADDRESS <u>4120 Rockwell</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James M. Lawrence</u>				4. DATE OF DEATH Month Day Year <u>May 3 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1905</u>		9. AGE (In years last birthday) <u>50 yrs.</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam fitter, bldg. building</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTH PLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James M. Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Blanche W. McManis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07846</u>		17. INFORMANT <u>James M. Lawrence</u> Address <u>4120 Rockwell</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>13. Cerebral aneurysm</u> Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James L. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James L. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 3, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 7 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. H. Smith</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED
MAY 2 1956
BUREAU A. S.

8653

CERTIFICATE OF DEATH

Reg. Dist. No.

08629
242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glendale				c. LENGTH OF STAY IN 1b 45 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				d. STREET ADDRESS Rural			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ELSIE KATHERINE TAYLOR				4. DATE OF DEATH Month Day Year August 18 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 March 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Finland	
12. CITIZEN OF WHAT COUNTRY? No							
13. FATHER'S NAME John Paakenen				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Elsie M. Owens				18. ADDRESS 2204 Clifton Ave. Baltimore, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE (2 Weeks)							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Day Years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 19 56 , to 18 Aug. 19 56 , that I last saw the deceased alive on 16 Aug. 19 56 , and that death occurred at 12:48 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John R. Buell M.D.				ADDRESS (Street, city or town, state) 402 Main St., Laurel, Maryland			
DATE SIGNED							
PHYSICIAN'S NAME (Type) John R. Buell M.D.				ADDRESS 402 Main St., Laurel, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/56		22c. NAME OF CEMETERY OR CREMATORY St. Georges Ch., Cemetery		22d. LOCATION (City, town, or county) (State) Glenn Dale Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <i>Miss John Young</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

AUG 22 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1003. Page 1 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8627 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18630

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1028 65th. Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lee Middle Andrew Last Thomas				4. DATE OF DEATH Month Aug. Day 30 Year 19 56			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 22, 1916	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Const., Co., Bldg. Va.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Walter Thomas				14. MOTHER'S MAIDEN NAME Anna Pollard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Jesse W. Thomas (Brother) Address Same Add. as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status asthmaticus DUE TO Conditions, if any, which gave rise to immediate cause (b) Bronchial asthma (c), stating the underlying cause last. DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney EXAMINER'S NAME (Type) John T. Maloney M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 8/30/56							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 8/31/56		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) S. E. Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Rollins Funeral Home Myrtle R. Rollins				24. RECEIVED BY REGISTRAR 2-56		25. REGISTRAR'S SIGNATURE Carrie Campbell	

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

18631

8552

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Floyd</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mr. Rainier</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Floyd</u>			
c. LENGTH OF STAY IN 1b <u>2 1/2 Mos.</u>				d. STREET ADDRESS <u>Route #3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3010-Grindel Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William L. Thompson</u>				4. DATE OF DEATH <u>8-9-56</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/14, 1889</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR <u>66</u> Months		IF UNDER 24 HRS. <u>66</u> Days		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>				11. BIRTHPLACE (State or foreign country) <u>Riverside, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>J. J. Thompson</u>			
14. MOTHER'S MAIDEN NAME <u>Isabelle Kemp</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>2-31-03-54</u>			
16. SOCIAL SECURITY NO. <u>2-31-03-5448</u>				17. INFORMANT <u>Eva Todd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Peripheral Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>15 yrs?</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Amputation left lower limb near hip - June 1956</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 6</u> , 19 <u>56</u> , to <u>Aug. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 7</u> , 19 <u>56</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David S. Clayman</u> M.D.				ADDRESS (Street, city or town, state) <u>6311 Baeto Ave. - Riverside</u>			
DATE SIGNED <u>8.9.56</u>				PHYSICIAN'S NAME (Type) <u>DAVID S. CLAYMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thompson Family Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Dugspur, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley Funeral Home, Inc.</u>				ADDRESS <u>Mr. Rainier, Md.</u>			
24a. REC'D BY REGISTRAR <u>AUG 13 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Jas. Seaver</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08632

8654

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Pr. Geo's Co.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Pr. Geo's Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glass Manor</u>		LENGTH OF STAY (in this place) <u>1- Year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glass Manor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>4904- Deal Drive S.E.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ROBERT W. THORNE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 13th 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 8- 1918</u>	9. AGE last birthday <u>37</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Friendly, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sidney Thorne</u>				14. MOTHER'S MAIDEN NAME <u>Katie Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W.W. #2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Estelle F. Thorne (Wife) 4904- Deal Drive, SE</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Pulmonary Tuberculosis</u>				<u>10 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8:30 am</u> <u>1956</u> to <u>11:00 am</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-12</u> , 19 <u>56</u> , and that death occurred at <u>7 A</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>Malcolm T. Lunt</u> M.D.				ADDRESS (Street, city, town, state) <u>1746 K-ST N.W. D.C.</u>		DATE SIGNED <u>8-13-56</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Suitland, Maryland.</u>	
24. REC'D BY REGISTRAR DATE <u>AUG 15 1956</u>		REGISTRAR'S SIGNATURE <u>Sidney H. Hedgcock</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>1661- Good Hope Road S</u>		ADDRESS <u>Washington, DC</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08633

8578

Reg. Dist. No. 241

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville c. LENGTH OF STAY IN 1b 6 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9301 19th Avenue				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 9301 19th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Lynner Van Herpe				4. DATE OF DEATH Month Day Year August 26 1956					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-20-1902		9. AGE (In years last birthday) 53 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) N. Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lars Lynner				14. MOTHER'S MAIDEN NAME Callie -----					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Leo J. Van Herpe, Same address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease (c), stating the underlying cause last. DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D. EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED August 26, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/28/56		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Warner B. Humphrey, Silver Spring, Md.</i>				24a. REC'D BY REGISTRAR DATE 8/28/56		24b. REGISTRAR'S SIGNATURE <i>James Slattery</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

1956

10/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

186634

Reg. Dist. No. 245

8628

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <u>West Virginia</u> b. COUNTY <u>Berkley</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u>			
c. LENGTH OF STAY IN 1b <u>5 months</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Heland Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA JANE Vinnds</u>				4. DATE OF DEATH Month Day Year <u>August 6 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-81</u>	9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. V.R.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Willow</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Wiley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Patients chart.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of ovary with metastases</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1944</u> to <u>Aug 6 1956</u> , that I last saw the deceased alive on <u>Aug 6 1956</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. W. Malin</u> M.D.				ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>8-6-56</u>			
PHYSICIAN'S NAME (Type) <u>L. W. Malin, M. D.</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>8/6/56</u>		<u>815 King St</u>		<u>Martinsburg W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch Sons Hgaltz</u> ADDRESS				24. REC'D BY REGISTRAR <u>Aug 6 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>	

BULLY

AUG 9 1930

8655

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Englewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Englewood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>1624 62nd Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Michelle Lynn Wallace</u>		4. DATE OF DEATH <u>8/10/56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morris F. Wallace Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Myrna Loy Hemingway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Morris F. Wallace Jr. (Father)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>IX</u> DUE TO (c) <u>child was mangled</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>child was mangled</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/20</u> , 19 <u>56</u> to <u>8/10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/7</u> , 19 <u>56</u> , and that death occurred at <u>2 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald H. Sheppard</u> M.D.		DATE SIGNED <u>1924 19th St. NW.</u>	
PHYSICIAN'S NAME (Type) <u>Donald H. Sheppard</u>		ADDRESS (Street, city or town, state) <u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-14-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARMONY CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert McHenry</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
ADDRESS <u>1870-9</u>		24b. REGISTRAR'S SIGNATURE <u>D. H. Sheppard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8656

CERTIFICATE OF DEATH

08636

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		d. STREET ADDRESS Apt. # 101 2018 37th Street, S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Lillie Viola Williams		4. DATE OF DEATH Month Day Year August 4, 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1889
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Johnstown, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Mintmier		14. MOTHER'S MAIDEN NAME --- Rader	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records at Suitland Nursing Home		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure DUE TO Multiple Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Days 9 Months 2 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 Sept., 1954, to August 4, 1956, that I last saw the deceased alive on August 3, 1956, and that death occurred at 10:35 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney W. Lowry M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) SIDNEY W. LOWRY MD		WASH. 28 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/4/56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Johnstown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24. REC'D BY REGISTRAR DATE	
25. REGISTRAR'S SIGNATURE Cassie Campbell			

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CERTIFICATE OF DEATH

08637

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle V Last Wilson		4. DATE OF DEATH Month Aug. Day 15 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Sept
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Taylor		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Norman T. Wilson		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis (c) Generalized Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 48 hrs year year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 14, 1956 to Aug 15, 1956 that I last saw the deceased alive on Aug 14, 1956 and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz		ADDRESS (Street, city or town, state) DATE SIGNED RFD Bowie Md 8/16/56	
PHYSICIAN'S NAME (Type) H. James Kurtz			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/18/56	22c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro Maryland
23. FUNERAL DIRECTOR'S SIGNATURE F. Gaseh's Sons		ADDRESS Hyattsville, Maryland	
24a. REC'D BY REGISTRAR UG 20 DEC		24b. REGISTRAR'S SIGNATURE Amadeo Amadeo	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08638
8657 CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)				c. LENGTH OF STAY IN 1b 8 mo's, 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1817 Kendall St., N.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Levi Middle C. Last Wright		4. DATE OF DEATH Month August Day 14 Year 19 56					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/03	9. AGE (In years lost birthday) yrs. 52	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs, self emp'd.		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi G. Wright				14. MOTHER'S MAIDEN NAME Annie Ball			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Decedent Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X right lung, Bronchogenic Carcinoma with metastases DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 9 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/30, 1955, to 8/14, 1956, that I last saw the deceased alive on 8/14/56, and that death occurred at 3:50p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Daniel Leo Finucane M.D. Glenn Dale Hospital, Glenn Dale, 8/14/56 PHYSICIAN'S NAME (Type) Daniel Leo Finucane Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8/15/56		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Stewart 304 H St NE Washington D.C.				24a. REC'D BY REGISTRAR DATE 8/14/56		24b. REGISTRAR'S SIGNATURE Moe Weiss	

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1. *Journal of the American Medical Association*, 1997; 277: 1039-1043.

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CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

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